

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047944

Facility Name: Pittsfield Manor

Address: 610 Lowry Street Pittsfield 62363
Number City Zip Code

County: Pike

Telephone Number: (800) 373-5202 Fax #: (217) 285-5212

HFS ID Number:

Date of Initial License for Current Owners: 04/26/06

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501 (c) (3)

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Brian Burger Telephone Number: (309) 343-1550
Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2024 to 9/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Brian Burger

(Title) Chief Financial Officer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

Paid Preparer

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Pittsfield Manor # 0047944 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>89</u>	Skilled (SNF)	<u>89</u>	<u>32,485</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>89</u>	TOTALS	<u>89</u>	<u>32,485</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,312	14,294	20		6,351	2,012	881	27,870	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,312	14,294	20		6,351	2,012	881	27,870	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 85.79%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 4/26/06

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 4/01/06 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 89

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 9/30/2025 Fiscal Year: 9/30/2025
* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	391,591	37,270	8,777	437,638		437,638	(47,739)	389,899			1
2	Food Purchase		357,095		357,095		357,095	(40,051)	317,044			2
3	Housekeeping	233,313	42,280		275,593		275,593	(54,621)	220,972			3
4	Laundry	85,817	35,787		121,604		121,604	(24,098)	97,506			4
5	Heat and Other Utilities			171,876	171,876		171,876	(34,011)	137,865			5
6	Maintenance	116,391	59,054	106,957	282,402		282,402	(58,370)	224,032			6
7	Other (specify):*											7
8	TOTAL General Services	827,112	531,486	287,610	1,646,208		1,646,208	(258,890)	1,387,318			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,867,240	178,735	1,944,655	4,990,630		4,990,630	(275,359)	4,715,271			10
10a	Therapy											10a
11	Activities	176,524	5,228		181,752		181,752	(45,442)	136,310			11
12	Social Services	52,537		17	52,554		52,554		52,554			12
13	CNA Training			2,748	2,748		2,748		2,748			13
14	Program Transportation			9,029	9,029		9,029		9,029			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,096,301	183,963	1,975,949	5,256,213		5,256,213	(320,801)	4,935,412			16
	C. General Administration											
17	Administrative	109,465			109,465		109,465		109,465			17
18	Directors Fees							1,274	1,274			18
19	Professional Services			321,678	321,678		321,678	958	322,636			19
20	Dues, Fees, Subscriptions & Promotions			43,117	43,117		43,117	(6,420)	36,697			20
21	Clerical & General Office Expenses	96,484	17,938	68,590	183,012		183,012	(1,705)	181,307			21
22	Employee Benefits & Payroll Taxes			568,561	568,561		568,561	(61,478)	507,083			22
23	Inservice Training & Education			1,842	1,842		1,842		1,842			23
24	Travel and Seminar			562	562		562		562			24
25	Other Admin. Staff Transportation			9,031	9,031		9,031		9,031			25
26	Insurance-Prop.Liab.Malpractice			125,726	125,726		125,726	(9,425)	116,301			26
27	Other (specify):*											27
28	TOTAL General Administration	205,949	17,938	1,139,107	1,362,994		1,362,994	(76,796)	1,286,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,129,362	733,387	3,402,666	8,265,415		8,265,415	(656,487)	7,608,928			29

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			61,160	61,160		61,160	188,873	250,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15	15		15	79,359	79,374			32
33	Real Estate Taxes							70,640	70,640			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			24,170	24,170		24,170		24,170			35
36	Other (specify):* Mortgage Ins							16,851	16,851			36
37	TOTAL Ownership			541,345	541,345		541,345	(100,277)	441,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			40,228	40,228		40,228		40,228			38
39	Ancillary Service Centers		111,413	340,745	452,158		452,158		452,158			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			490,579	490,579		490,579		490,579			42
43	Other (specify):* Disallowed Costs			223,238	223,238		223,238	(223,238)				43
44	TOTAL Special Cost Centers		111,413	1,094,790	1,206,203		1,206,203	(223,238)	982,965			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,129,362	844,800	5,038,801	10,012,963		10,012,963	(980,002)	9,032,961			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,423)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,419)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(510)	20		17
18	Fines and Penalties	(55,093)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(138,748)	43		24
25	Fund Raising, Advertising and Promotional	(12,430)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(761,789)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,008,412)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	28,410		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 28,410		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (980,002)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (2,789)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Maintenance Fee Income Offset	(2,400)	6	3
4	Offset Vending Income	(355)	2	4
5	Disallow Lab Expense	(9,178)	43	5
6	Disallow X-Ray Expense	(1,967)	43	6
7	Disallow R/E Entity Professional Fees	(30,585)	19	7
8	Disallow AL Expenses-Dietary	(47,739)	1	8
9	Disallow AL Expenses-Food	(39,696)	2	9
10	Disallow AL Expenses-Housekeeping	(54,621)	3	10
11	Disallow AL Expenses-Laundry	(24,098)	4	11
12	Disallow AL Expenses-Utilities	(34,011)	5	12
13	Disallow AL Expenses-Maintenance	(55,970)	6	13
14	Disallow AL Expenses-Nursing	(275,359)	10	14
15	Disallow AL Expenses-Activities	(45,442)	11	15
16	Disallow AL Expenses-Telephone	(2,942)	21	16
17	Disallow AL Expenses-Employee Benefits	(61,478)	22	17
18	Disallow AL Expenses-Insurance	(26,793)	26	18
19	Disallow AL Expenses-Interest Expense	(19,851)	32	19
20	Disallow AL Expenses-Real Estate Tax Expense	(17,660)	33	20
21	Disallow AL Expenses-MIP Insurance	(4,213)	36	21
22	Disallow AL License Fees	(2,443)	20	22
23	Disallow AL IHCA Dues	(800)	20	23
24	Disallow Loss on Disposal	(1,399)	43	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
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34				34
35				35
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(761,789)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Page 6 Supplemental		
		Community Living Options, Inc. (CLO)				
		See Page 6 Supplemental for specific homes				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Director Fees	\$	Unlimited Development, Inc.	100.00%	\$ 1,274	\$ 1,274	1
2	V	19	Professional Fees		Unlimited Development, Inc.	100.00%	958	958	2
3	V	20	Dues, Licenses and Subs		Unlimited Development, Inc.	100.00%	47	47	3
4	V	21	General Admin Expense		Unlimited Development, Inc.	100.00%	1,237	1,237	4
5	V	26	Property Insurance		Unlimited Development, Inc.	100.00%	1,008	1,008	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 4,524	\$ *	4,524 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	Pittsfield Lowry, LLC	N/A	\$ 30,585	\$ 30,585	15
16	V	20	Dues, Fees, Subs & Prom		Pittsfield Lowry, LLC	N/A	75	75	16
17	V	26	Property Insurance		Pittsfield Lowry, LLC	N/A	16,360	16,360	17
18	V	30	Depreciation		Pittsfield Lowry, LLC	N/A	224,292	224,292	18
19	V	32	Interest Expense	46	Pittsfield Lowry, LLC	N/A	99,256	99,210	19
20	V	33	Property Taxes		Pittsfield Lowry, LLC	N/A	88,300	88,300	20
21	V	34	Facility Rent	456,000	Pittsfield Lowry, LLC	N/A		(456,000)	21
22	V	36	Mortgage Insurance		Pittsfield Lowry, LLC	N/A	21,064	21,064	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 456,046			\$ 479,932	\$ * 23,886	39

STATE OF ILLINOIS

Ownership Listing-1

Pittsfield Manor

ID#

0047944

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Ownership Percentage

Ownership Percentage

Ownership Percentage

Place of Residence

City

State

First Name

M.I.

Last Name

1	Board of Directors:								1
2									2
3	Robert		Wagner						3
4	Jerry		Gilmore						4
5	David		Haney						5
6	Audrey		Finke						6
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Facility Name & ID Number

Pittsfield Manor

0047944

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Community Living Options, Inc.	100%			Allen Court	Clinton	CILA	1
2	Community Living Options, Inc.	100%	Beardstown Terrace	Beardstown				2
3	Community Living Options, Inc.	100%	Bellefontaine Place	Waterloo				3
4	Community Living Options, Inc.	100%	Braun's Terrace	Greenville				4
5	Community Living Options, Inc.	100%	Carthage Terrace	Carthage				5
6	Community Living Options, Inc.	100%	Curtiss Court	Springfield				6
7	Community Living Options, Inc.	100%	Davies Square	Pekin				7
8	Community Living Options, Inc.	100%	Douglas Terrace	Jacksonville				8
9	Community Living Options, Inc.	100%	Edwardsville Terrace	Edwardsville				9
10	Community Living Options, Inc.	100%	Effingham Terrace	Effingham				10
11	Community Living Options, Inc.	100%			Eisenhower Terrace	Jacksonville	CILA	11
12	Community Living Options, Inc.	100%	Freeburg Terrace	Freeburg				12
13	Community Living Options, Inc.	100%	Froehlich House	Galesburg				13
14	Community Living Options, Inc.	100%	Gaines Mill Place	Springfield				14
15	Community Living Options, Inc.	100%	Glenwood Terrace	Springfield				15
16	Community Living Options, Inc.	100%			Hawthorne Terrace	Galesburg	CILA	16
17	Community Living Options, Inc.	100%	Highview Terrace	Paris				17
18	Community Living Options, Inc.	100%	Jacksonville Group Homes:					18
19	Community Living Options, Inc.	100%	Anna Terrace	Jacksonville				19
20	Community Living Options, Inc.	100%	Campbell Court	Jacksonville				20
21	Community Living Options, Inc.	100%	LaFayette Terrace	Jacksonville				21
22	Community Living Options, Inc.	100%	Kepley House	Pittsfield				22
23	Community Living Options, Inc.	100%	Lawrence Place	Lincoln				23
24	Community Living Options, Inc.	100%	Lincoln Terrace	Lincoln				24
25	Community Living Options, Inc.	100%	Maple Terrace	Quincy				25
26	Community Living Options, Inc.	100%	Plonka Terrace	Galesburg				26
27	Community Living Options, Inc.	100%	Quincy Terrace	Quincy				27
28	Community Living Options, Inc.	100%	Schultz House	Danville				28
29	Community Living Options, Inc.	100%	Stevens House	Galesburg				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Pittsfield Manor

0047944

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Community Living Options, Inc.	100%	Tanner Place	Paris				1
2	Community Living Options, Inc.	100%	Taylor House	Springfield				2
3	Community Living Options, Inc.	100%	Thelma Terrace	Wood River				3
4	Community Living Options, Inc.	100%	Trulson House	Galesburg				4
5	Community Living Options, Inc.	100%	Vable Terrace	Jerseyville				5
6	Community Living Options, Inc.	100%	Walsh Terrace	Galesburg				6
7	Community Living Options, Inc.	100%	Wetherell Place	Effingham				7
8	Community Living Options, Inc.	100%	Woodriver Group Homes:					8
9	Community Living Options, Inc.	100%	Aberdeen Terrace	Alton				9
10	Community Living Options, Inc.	100%	Linton Terrace	Wood River				10
11	Community Living Options, Inc.	100%	Madison Terrace	Wood River				11
12	Community Living Options, Inc.	100%	Pershing Terrace	Wood River				12
13	Community Living Options, Inc.	100%			Audrey Court	Clinton	CILA	13
14	Unlimited Development, Inc. (UDI)	100%	Parkway Manor	Marion				14
15	Unlimited Development, Inc. (UDI)	100%			Parkway Estates	Marion	Retirement living ce	15
16	Unlimited Development, Inc. (UDI)	100%	Maryville Manor	Maryville				16
17	Unlimited Development, Inc. (UDI)	100%	Shelbyville Manor	Shelbyville				17
18	Unlimited Development, Inc. (UDI)	100%			Liberty Estates of Car	Carbondale	Retirement living ce	18
19	Unlimited Development, Inc. (UDI)	100%	Seminary Manor	Galesburg				19
20	Unlimited Development, Inc. (UDI)	100%			Seminary Estates	Galesburg	Retirement living ce	20
21	Unlimited Development, Inc. (UDI)	100%			Hawthorne Inn of Gals	Galesburg	Assisted Living Faci	21
22	Unlimited Development, Inc. (UDI)	100%	Centralia Manor	Centralia				22
23	Unlimited Development, Inc. (UDI)	100%			Centralia Estates	Centralia Estates	Retirement living ce	23
24	Unlimited Development, Inc. (UDI)	100%	Pittsfield Manor	Pittsfield				24
25	Unlimited Development, Inc. (UDI)	100%	Pekin Manor	Pekin				25
26	Unlimited Development, Inc. (UDI)	100%			Pekin Estates	Pekin	Retirement living ce	26
27	Unlimited Development, Inc. (UDI)	100%	Jerseyville Manor	Jerseyville				27
28	Unlimited Development, Inc. (UDI)	100%	Manor Court of Carbondale	Carbondale				28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Unlimited Development, Inc. (UDI)	100%	River Hills Manor	Keokuk, IA				1
2	Unlimited Development, Inc. (UDI)	100%			River Hills Estates	Keokuk, IA	Retirement living ce	2
3	Unlimited Development, Inc. (UDI)	100%			River Hills Inn	Keokuk, IA	Assisted living facili	3
4	Unlimited Development, Inc. (UDI)	100%			Centralia East McC	Galesburg	Lessor	4
5	Unlimited Development, Inc. (UDI)	100%			Galesburg North Semi	Galesburg	Lessor	5
6	Unlimited Development, Inc. (UDI)	100%			Jerseyville North State	Galesburg	Lessor	6
7	Unlimited Development, Inc. (UDI)	100%			Shelbyville Route 128,	Galesburg	Lessor	7
8	Unlimited Development, Inc. (UDI)	100%			Marion Willimason Co	Galesburg	Lessor	8
9	Unlimited Development, Inc. (UDI)	100%			2245 Seminary Street,	Galesburg	Lessor	9
10	Unlimited Development, Inc. (UDI)	100%			Pittsfield Lowry, LLC	Galesburg	Lessor	10
11	Unlimited Development, Inc. (UDI)	100%			Pekin El Camino, LLC	Galesburg	Lessor	11
12	Unlimited Development, Inc. (UDI)	100%			Keokuk Village Circle	Galesburg	Lessor	12
13	Unlimited Development, Inc. (UDI)	100%			The Kensington	Galesburg	Supportive Living	13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule 7A								\$ 1,274	L18, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,274		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge Realty Capital		X	Facility purchase	\$19,553.00	5/1/2012	\$ 4,557,600	\$ 3,263,545	6/1/2045	3.5500	\$ 79,405	1							
2	LTD. of Illinois			SNF portion								2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$19,553.00		\$ 4,557,600	\$ 3,263,545			\$ 79,405	9							
	B. Non-Facility Related*																		
10	Cambridge Realty Capital		X	Facility purchase -AL Portion	\$4,888.00	5/1/2012	1,139,400	815,886	6/1/2045	3.5500	19,851	10							
11	LTD. of Illinois								Misc Interest		15	11							
12									Disallow AL Int Exp		(19,851)	12							
13									Int Income Offset		(46)	13							
14	TOTAL Non-Facility Related				\$4,888.00		\$ 1,139,400	\$ 815,886			\$ (31)	14							
15	TOTALS (line 9+line14)						\$ 5,697,000	\$ 4,079,431			\$ 79,374	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 16,851 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	65,055	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2024		\$	92,042	2
3. Under or (over) accrual (line 2 minus line 1).				\$	26,987	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	61,313	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Less AL Allocation of Expenses			(17,660)	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	70,640	7
Assessed Value from Real Estate Tax Bill:	2024	1,450,340	8			
Real Estate Tax Bill for Calendar Year:	2020	79,606	9			
	2021	78,789	10			
	2022	81,731	11			
	2023	86,648	12			
	2024	92,042	13			
This facility was purchased from an unrelated for-profit entity during 2006. A tax exemption has not yet been obtained.						
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.						
Real estate taxes reported on Sch V line 33 have been reduced by an allocation of expenses relating to ALC services based on as estimated 20%. Taxes paid during year represents the entire 2024 bill.						

FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	\$ 14
15	PLUS APPEAL COST FROM LINE 5	\$ 15
16	LESS REFUND FROM LINE 6	\$ 16
17	AMOUNT TO USE FOR RATE CALCULATION	\$ 17

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,520B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Assisted Living-22 Units

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility-SNF	2.6 Acres	2006	\$ 144,000	1
2	Facility-SNF	.06 Acres	2013	1,662	2
3	TOTALS	#VALUE!		\$ 145,662	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	89		2006	1990	\$ 5,262,410	\$	40	\$ 131,560	\$ 131,560	\$ 2,565,410
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping			2006	4,720		10			4,720
10	Water Heater, Replaced Sheetrock Ceilings (gypsum)			2008	8,087		10			8,087
11	Shetrock wlls/repl ceiling/repl tiles, Wall light/bdside tbls/chairs/nightstand			2008	40,507		10-15 yrs			40,507
12	Roof, Furnance and A/C, Gutters, Fire sprinkler			2009	360,644	6,661	10-25 yrs	6,661		303,474
13	Sprinkler System/Carpet/Carpet/Carpeting			2009	22,969	197	5-25 yrs	197		21,227
14	Parker Tub Rm-Sink,Mirror,toilet,shwr walls,flr,drywall,drains,plumbing			2011	44,775		12			44,775
15	Parking Lot Overlay and Sealcoat			2011	52,770		8			52,770
16	Hallway-Handrails/whlchair guards/covebs/paint/light/insulation/wall gua			2012	57,129		12			57,129
17	Water Heater			2012	3,691		10			3,691
18	Water Softener			2012	2,522		10			2,522
19	Water Heater			2012	3,760		10			3,760
20	Cable TV System			2013	5,014		10			5,014
21	Water Softener			2013	2,633		10			2,633
22	Physical Therapy Addition (contracted total)			2013	269,325		12	22,444	22,444	265,583
23	Dining Room Addition (contracted total)			2013	238,316		12	19,859	19,859	235,005
24	Water Heater			2015	3,705	154	10	154		3,705
25	Water Heater			2015	4,012	334	10	334		4,012
26	AC Unit/Coil			2015	3,905	326	10	326		3,905
27	AC Unit-Kitchen			2016	4,762		5			4,762
28	Electric Panel			2017	3,100	206	15	206		1,791
29	Bathroom 2 Remodel-Tile/Shower/Fixtures/Paint			2017	28,600	2,383	12	2,383		19,662
30	Coil-AC Unit - Laundry Room and Front Hallway			2018	4,482	299	15	299		2,116
31	Handrails - 200 Hallway			2018	7,457	497	15	497		3,521
32	Dining Room - Vinyl Plank Flooring/Lights			2019	26,145	2,615	10	2,6		

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kohler Generator	2019	\$ 4,715	\$ 157	5	\$ 157	\$	\$ 4,715	37
38	Wall Guards/Door Guards/End Caps Throughout Facility	2020	3,681	368	10	368		2,086	38
39	Water Heater - Service Hallway Water Heater Room	2020	3,550	355	10	355		2,012	39
40	AC Unit - 400 Hall	2020	3,465	520	5	520		3,465	40
41	Landscaping-Front of Nursing Home	2020	8,500	850	10	850		4,746	41
42	New Water Heater - Service Hall Mechanical Room	2020	4,880	488	10	488		2,358	42
43	New Walk In Cooler	2021	4,650	310	15	310		1,447	43
44	New Water Heater - Service Hall Mechanical Room	2021	6,142		10	614	614	2,559	44
45	Bathroom #2 - New Showers/Fixtures/Tile	2021	35,800		12	2,983	2,983	12,181	45
46	Install New 3 Phase AC Unit with Coil	2021	3,557		10	356	356	1,602	46
47	Bathroom #1-New Tile/Shower/Fixtures/Toilet/Vanity/Drywall/Ca	2022	72,268		12	6,022	6,022	22,583	47
48	Kitchen Remodel - New Flooring/Water Lines & Shut Offs/Plumb	2022	38,709		12	3,226	3,226	12,097	48
49	Electric/New Wallcoverings/Tile Base								49
50	Replaced Fire Alarm Panel	2022	9,509		15	634	634	2,166	50
51	Parking Lot - Asphalt Sealcoat/Crack Sealing/Striping	2022	10,956		8	1,370	1,370	4,452	51
52	Asphalt - 340 Square Yards -Tear Out & Replace Section of Parki	2022	16,500	2,062	8	2,062		6,531	52
53	2 New Steel Doors in Kitchen	2022	5,554	555	10	555		1,574	53
54	Replace Sidewalk	2023	6,356	424	15	424		1,059	54
55	3 PTAC Units with Thermostats	2024	2,512	502	5	502		586	55
56	Double Faced Lighted Outdoor Sign	2024	4,415	442	10	442		773	56
57	2 New Furnaces/Coils	2024	6,958	464	15	464		734	57
58	New Water Heater - Mechanical Room	2024	6,346	635	10	635		1,005	58
59	New Generator	2024	9,847	985	10	985		1,395	59
60	New Water Heaters - Mechanical Room	2024	13,065	1,307	10	1,307		1,742	60
61	New AC Unit	2024	7,844	1,569	5	1,569		2,092	61
62	2 New Water Heaters - 200 Hall	2024	9,200	920	10	920		1,227	62
63	New Water Heater - 200 Hall	2024	3,600	360	10	360		420	63
64	Repair Shower Rm Floor - 400 Hall	2024	2,860	286	10	286		286	64
65	Install 4 Magnetic Door Closures	2024	2,923	292	10	292		292	65
66	Replace Sidewalk	2024	2,973	272	10	272		272	66
67	New Water Heater - Mechanical Room	2024	3,800	317	10	317		317	67
68	Replace Copper Water Lines - Laundry Rm	2025	2,500	188	10	188		188	

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,798,174	\$ 29,678		\$ 218,746	\$ 189,068	\$ 3,780,549	1
2	New Furnace	2025	2,570	86	10	86		86	2
3	New Water Softener	2025	6,500	108	10	108		108	3
4	New Steel Insulated Door-Memory Lane Courtyard Door	2025	5,011	42	10	42		42	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,812,255	\$ 29,914		\$ 218,982	\$ 189,068	\$ 3,780,785	34

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 215,952	\$ 15,932	\$ 15,932	\$	5-15 yrs	\$ 155,521	71
72	Current Year Purchases	88,787	7,444	7,444		5-15 yrs	7,444	72
73	Fully Depreciated Assets	455,647					455,647	73
74								74
75	TOTALS	\$ 760,386	\$ 23,376	\$ 23,376	\$		\$ 618,612	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC G350 Van	2006	\$ 29,848	\$	\$	\$	4	\$ 29,848	76
77	Patient Care	2017 Ford Starcraft Bus	2017	59,678				4	59,678	77
78	Facility	2016 Toyota Corolla	2023	11,663	2,916	2,916		4	5,589	78
79	Patient Care	2017 Ford T350 Starcraft	2025	38,075	4,759	4,759		4	4,759	79
80	TOTALS			\$ 139,264	\$ 7,675	\$ 7,675	\$		\$ 99,874	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,857,567	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,965	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 250,033	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 189,068	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,499,271	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Leasehold Improvements-AL	\$ 3,897	\$ 195	\$ 195	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,897	\$ 195	\$ 195	91

G. Construction-in-Progress

	Description	Cost	
92	New Roof	\$ 105,107	92
93			93
94			94
95		\$ 105,107	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A- Facility Owned
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 24,170 Description: Medical Equipment \$20,846; Miscellaneous \$3,324
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 2,748	\$	\$ 2,748
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,748	\$	\$ 2,748
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,748			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	5,117	\$ 174,173	\$	5,117	\$ 174,173	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		327	19,363		327	19,363	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		4,295	147,209		4,295	147,209	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				111,413		111,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (57,478)	\$ 109,455	1
2	Cash-Patient Deposits	188,649	188,649	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,000)	1,241,569	1,326,619	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,238	129,958	6
7	Other Prepaid Expenses	1,928	12,805	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,490,906	\$ 1,767,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		145,662	13
14	Buildings, at Historical Cost	932,411	6,812,255	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	542,324	899,650	16
17	Accumulated Depreciation (book methods)	(1,081,750)	(4,499,271)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (see Schedule 17A)	105,107	969,889	22
23	Other(specify): See Schedule 17A		590,813	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 498,092	\$ 4,918,998	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,988,998	\$ 6,686,484	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 506,660	\$ 875,403	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	188,649	188,649	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,052	97,052	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		61,313	32
33	Accrued Interest Payable		8,125	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	9,283,153	11,209,433	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,075,514	\$ 12,439,975	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,079,431	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	39,000	39,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 39,000	\$ 4,118,431	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,114,514	\$ 16,558,406	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,125,516)	\$ (9,871,922)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,988,998	\$ 6,686,484	48

Facility Name: Pittsfield Manor

IDPH License ID Number: 0047944

Fiscal Year End: 9/30/2025

Schedule 17A

XV. Balance Sheet

Line 22 Long Term Assets Other (specify):

	Operating	After Consolidation
Land-Assisted Living		36,000
Building-Assisted Living		1,315,602
Reserve for Depr-Building-Assisted Living		(641,348)
Dining Room Addition-Assisted Living		59,579
Reserve for Depr-Dining Room Addition-Assisted Living		(58,753)
Leasehold Improvements - Assisted Living		3,897
Reserve for Depr-Leasehold Improvements-Assisted Living		(195)
Construction in Progress	105,107	255,107
TOTAL	105,107	969,889

Line 23 Other

	Operating	After Consolidation
Replacement Reserve		466,949
Real Estate Tax Escrow		60,986
Insurance Escrow		2,406
MIP Escrow		60,472
TOTAL		590,813

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,269,742)	1
2	Restatements (describe):		2
3	Prior Period Adjustment- Liability Settlement Adj	(12,500)	3
4	Prior Period Adjustment- Intercompany Adj	229	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,282,013)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,843,503)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,843,503)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (8,125,516)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Pittsfield Manor

0047944

Report Period Beginning: 10/1/2024

Ending: 9/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,997,892	1
2	Discounts and Allowances for all Levels	(23,161)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,974,731	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,602	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 184,602	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	355	12
13	Barber and Beauty Care	2,530	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,352	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,974	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,211	23
	D. Non-Operating Revenue		
24	Contributions	980	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 980	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Late Payment/Processing Fees	536	28
28a	Maintenance Fee Income	2,400	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,936	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,169,460	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,646,208	31
32	Health Care	5,256,213	32
33	General Administration	1,362,994	33
	B. Capital Expense		
34	Ownership	541,345	34
	C. Ancillary Expense		
35	Special Cost Centers	715,624	35
36	Provider Participation Fee	490,579	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,012,963	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,843,503)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,843,503)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,173,463.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	3,364,623.00	45
46	MMAI-Medicaid is the Primary Payer	5,443.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,456,684.00	48
49	Medicare Part A	1,222,650.00	49
50	Other-(specify) Medicare Replacement/Managed Care MCA	123,781.00	50
51	Other-(specify) Hospice	129,837.00	51
52	Other-(specify) Assisted Living	498,250.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,974,731	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,851	1,940	\$ 93,332	\$ 48.11	1
2	Assistant Director of Nursing	2,181	2,206	92,203	41.80	2
3	Registered Nurses	5,740	6,108	252,909	41.41	3
4	Licensed Practical Nurses	17,118	18,138	619,102	34.13	4
5	CNAs & Orderlies	69,236	73,002	1,707,805	23.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,573	1,661	31,582	19.01	9
10	Activity Assistants	8,748	9,498	144,942	15.26	10
11	Social Service Workers	2,153	2,342	52,537	22.43	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,064	42,770	20.72	13
14	Head Cook	1,467	1,646	28,897	17.56	14
15	Cook Helpers/Assistants	19,083	20,231	319,924	15.81	15
16	Dishwashers					16
17	Maintenance Workers	4,951	5,386	116,391	21.61	17
18	Housekeepers	13,134	14,503	233,313	16.09	18
19	Laundry	5,028	5,528	85,817	15.52	19
20	Administrator	2,009	2,141	109,465	51.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,745	4,061	96,484	23.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator	1,655	1,735	59,016	34.01	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,143	2,253	42,873	19.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,736	174,443	\$ 4,129,362 *	\$ 23.67	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 8,777	L1, C3	35
36	Medical Director	Monthly	19,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,676	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,953		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,809	\$ 504,951	L10, C3	50
51	Licensed Practical Nurses	6,840	410,389	L10, C3	51

STATE OF ILLINOIS

Facility Name & ID NumberPittsfield Manor# 0047944Report Period Beginning: 10/1/2024Ending: 9/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Michelle Hartman

Function

Administrator

Ownership

None

Amount

\$ 109,465

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.)

\$ 109,465

B. Administrative - Other

Description

N/A

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)
(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

RFMS, Inc.

Type

Administrative Services

Amount

\$ 138,600

LTC Support Services, LLC

Support Services

135,024

RSM US LLP

Accounting Services

21,292

Templin Healthcare Accounting

Accounting Services

4,428

Guided Care

MCO Guide

4,990

Polsinelli

Legal Services

17,344

TOTAL (agree to Schedule V, line 19, column 3)
(For legal fee disclosure, see page 39 of instructions)

\$ 321,678

D. Employee Benefits and Payroll Taxes

Description

Workers' Compensation Insurance

Amount

\$ 47,217

Unemployment Compensation Insurance

25,926

FICA Taxes

305,850

Employee Health Insurance

165,567

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

401k

Other Employee Benefits

12,868

Disallow AL Allocated Costs

(61,478)

TOTAL (agree to Schedule V,
line 22, col.8)

\$ 507,083

E. Schedule of Non-Cash Compensation Paid
to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

IDPH License Fee

Amount

\$ 1,992

Advertising: Employee Recruitment

22,671

Health Care Worker Background Check
(Indicate # of checks performed 48)

4,000

Patient Background Checks

33

Association Dues (total from pg 22, #4)

7,863

Subscriptions

2,294

Other Licenses & Fees

3,361

Disallow AL Allocated Costs

(3,243)

Indirect costs

122

Less: Public Relations Expense

(510)

PAC and Lobbying payments

(2,789)

All non-allowable advertising

()

TOTAL (agree to Sch. V,
line 20, col. 8)

\$ 36,697

G. Schedule of Travel and Seminar**

Description

Out-of-State Travel

Amount

\$

In-State Travel

562

Seminar Expense

Entertainment Expense

()

TOTAL (agree to Sch. V,
line 24, col. 8)

\$ 562

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
<u>IL HEALTHCARE ASSOCIATION (IHCA)</u>	<u>5,074</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>5,074</u> Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

<u>IL HEALTHCARE ASSOCIATION (IHCA)</u>	<u>2,789</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>2,789</u> Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

<u>IL HEALTHCARE ASSOCIATION (IHCA)</u>	<u>7,863</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
<u> </u>	<u>7,863</u> Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	<u>49,736</u>	Line	<u>10</u>
----	---------------	------	-----------
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	<u>490,579</u>
----	----------------

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$	<u>N/A</u>	Has any meal income been offset against related costs?	<u>N/A</u>	Indicate the amount.	\$ <u>N/A</u>
----	------------	--	------------	----------------------	---------------
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: RSM US LLP

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.